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In the matter of Docket 02-60

"RURAL AREAS"

The underlying concept to use the US Census Metropolitan Statistical Areas (MSA) to determine initial urban/rural status is superb. In addition to the MSA being the first sites for competitive telecommunication local service options, hospitals located in an MSA tend to be the apex for specialized health care services. Non MSA hospitals provide the primary care and services to the local community.

A major challenge to providing support for our rural hospitals is MSA creep. Adjacent counties can be effected by the concept of MSA creep where "outlying counties are included if they meet specific requirements of commuting to or from the (core) central counties." While this mumbo gumbo works well with someone sitting at the Census Bureau, a patient seeking medical assistance will first visit their local clinic/hospital before undertaking the "commute" to the metropolitan jungle. While driving ½ hour or more for employment may be the norm, visiting the family physician is a local undertaking.

Goldsmith addressed a similar situation associated with a single county. A portion of a county may be very urban in nature while the far side of the same county is rural. This happens for large counties and for counties that have a city with an MSA designation but the countywide population is sparse. In the later case, the county or regional hospital in the MSA designated area is excluded from the program. The hospital providing the critical initial contact is excluded from the program.

Currently, there are 91 counties that have a Goldsmith exception to allow rural portions in an otherwise urban county to be supported. With the Goldsmith Modifications abandoned for the 2000 census, how will we address the areas that are in need?

After reviewing the comments, I wondered how well Goldsmith worked. At the same time, it appeared the California group was really whinnying and I don't mean Chardonnay.

Under Goldsmith, 21 counties in California have been partially designated as Rural. Included in this list are Los Angles and Santa Clara counties. With a population density of 2300+/ square mile for LA County and 1300+/ square mile for Santa Clara County. Does a county with 8 million people belong on the list?

Goldsmith may have not been perfect, but we do need to correct some shortcomings using the MSA. While we need to address fairness, I don't think we have to dismantle the entire system for the benefit of expanding the number of eligible provider locations. The truth is there is urban, rural and the gray zone of suburbia. It's that gray area of being not quite in town and not being far enough out that's the issue.

Some have suggested throwing out the entire system. Using the definition from any state or federal agencies to help promote a county as "Rural" or "Underserved". Everyone can site an example or two where a deserving health care facility is in the shadow of a large urban area. The concept of going shopping for some language, from some department, at some state or federal level, is wrong. It's similar to receiving a 4-year degree from a diploma mill. A piece of paper doesn't make it true.

And while "I know a Rural area when I see it", it normally has cows. The basis for support must be based on people. Fewer people in a given region translates into fewer health care facilities, fewer financial resources, and longer drive times to adequate health care.

Corrections to the MSA Urban areas must be based on population. A county with a population density of less than 99 people / square mile would be classified as RURAL. Support would be provided for all locations in the county except within the associated boundaries of the MSA Principle City. Counties with populations under

Therefore, I support the FCC in modifying the program to incorporate a population density correction based on US Census information.

- Fund MSA Rural Counties under the existing rules
- Fund MSA Urban Counties with a population density of 99 people/squ. mile or less. The MSA Principle City would continue to be treated as Urban.
- Fund MSA Urban Counties with a total population of 50,000 people or less
- Current HCPs that become designated as Urban would continue to receive support until existing services under contract expire

By replacing Goldsmith with population density, we'll provide support to the intended rural population of the country.

"ADMINISTRATIVE CHANGES"

Direct support payments from USAC to the HCP.

The current system provides a support payment schedule to the carrier that is the basis for a billing credit. The coordinator for the carrier places an internal request with the accounting group to apply the credit. The credit suddenly appears on the bill, or part of a payment, or a catch-up payment.

Tracking the payments has become a very time consuming process. For a majority of HCPs, the telephone bills are routed to accounting for payment. In order to confirm payment, the bills need to be pulled from the files and reviewed manually. If multiple services are being supported, the information needs to be collected and often times placed in a spreadsheet to assist in adding the individual credits. If an underpayment is discovered, there may be a multiple month cycle to eventually see the credit on the bill.

USAC has streamlined the upfront process. 465s posted effortlessly, 466s easy to complete with prefilled information, 468s gone (thank God), 467s E-certified quickly. The OMB has estimated the time to complete these tasks. However, the carrier-HCP payment interaction is untracked and flawed.

Now it's time to address the backend of the process. The simplest method to minimize the time required to audit the payments is to hold up sending in 466s or holding up the 467 E-certification. The result is a single payment being applied by the carrier. The single payment is made because the funding year is over.

This work around is created because the primary problem is time. The hospital staff does not have "free time" and so they must create ways to become more efficient. The solution is to have checks with the appropriate funding information sent directly to the HCP. This would speed the process and encourage early posting, early submission, and early certification. The current system punishes the "early birds."

- Send support payments directly from USAC to HCP

Your efforts on this issue are desperately needed.

"CHANGES FOR FY2004"

The changes implemented for FY 2004 enhanced the ability of the HCP to meet their obligations to the community. The addition of Internet support, MAD expansion, similar services comparison, and use of any urban area all combine to allow more funds to needed services and easier comparisons with urban markets.

"RHCD STAFF at WHIPPANY"

While the Health Care Providers struggle with the forms and process, the RHCD Staff is always there to help pave the way with knowledge and experience as we negotiate the twists and turns of the program. Without their dedication and desire to help us be successful, we would often be lost.

I thank each one for their help.

Michael O’Connor